Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Home Infusion Therapy/ Parenteral Nutrition Program

Billing Instructions

(Formerly known as Infusion/Enteral/Parenteral)

[WAC 388-553]

About this publication

This publication supersedes all previous Infusion/Enteral/Parenteral Billing Instructions and Numbered Memoranda 01-42 MAA, 02-06 MAA, and 02-53 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

Table of Contents

Table of Contents (cont.)

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Where do I send my request for a limitation extension and/or prior authorization?

Follow the instructions listed in the *Authorization* section in these billing instructions and fax/write to:

(360) 586-1471 FAX

Division of Medical Management
Home Infusion Therapy/Parenteral Nutrition Program Manager
PO Box 45506
Olympia, WA 98506-5506

Who do I contact if I have questions on…

Payments, denials, general questions regarding claims processing, Healthy Options?

Medical Assistance Customer Service Center (800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

How do I obtain copies of billing instructions or numbered memoranda?

Check out MAA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

This is a blank page.

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Authorization – MAA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. MAA may require the provider to submit a written report to determine reimbursement. [WAC 388-500-0005]

Client – An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) – Rules adopted by the federal government. [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The Core Provider Agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies - Supplies that may be used once, or more than once, but cannot be used for an extended period of time. [WAC 388-500-0005]

Durable Medical Equipment (DME) – Equipment that:

(a) Can withstand repeated use;
(b) Is primarily and customarily used to serve a medical purpose;
(c) Generally is not useful to a person in the absence of illness or injury; and
(d) Is appropriate for use in the client's place of residence.

[WAC 388-500-0005]

Duration of Therapy - The estimated span of time that therapy will be needed for a medical problem. [WAC 388-553-200]

Emergency Medical Services – Medical services required by and provided to a patient experiencing an emergency medical condition. [WAC 388-500-0005]

Episode - A continuous period of treatment regardless of the number of therapies involved.

Explanation of Benefits (EOB) – A coded message on the medical assistance Remittance and Status Report that gives detailed information about the claim associated with that report. [WAC 388-500-0005]

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Health Care Payment and Remittance Advice - The Health Care Payment and Remittance Advice is the standard X-12 transaction, number 835, implemented as part of the federal Health Insurance Portability and Accountability Act (HIPAA). The 835 is the HIPAA alternative to the Remittance and Status Report (RA). It is intended for provider use in reconciling claims.

Home Health Agency - An agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence. [WAC 388-551-2010]

Hyperalimentation – See "Parenteral Nutrition." [WAC 388-553-200]

Infusion Therapy – The provision of therapeutic agents or nutritional products to individuals by parenteral infusion for the purpose of improving or sustaining a client's health. [WAC 388-553-200]

Infusion Therapy Provider - An entity or individual who has been authorized by MAA to provide equipment and supplies for parenteral administration of therapeutic agents to medical assistance clients.

Intradialytic Parenteral Nutrition (IDPN) - Intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition. [WAC 388-553-200]

Internal Control Number (ICN) - A 17-digit number that appears on your *Remittance and Status Report* by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Limitation Extension – A process for requesting reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization. [WAC 388-500-0005]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the categorically needy program (CNP) or medically needy program (MNP). [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Consultant - A physician employed by the department. [WAC 388-500-0005]

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program, for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Disposable supplies, which are used once and discarded. [WAC 388-500-0005]

Parenteral Infusion – The introduction of a substance by means other than the gastrointestinal tract, referring particularly to the introduction of substances by intravenous, subcutaneous, intramuscular or intramedullary means. [WAC 388-553-200]

Parenteral Nutrition - The provision of nutritional requirements intravenously. Also known as **Total Parenteral Nutrition (TPN) or Hyperalimentation**
[WAC 388-553-200]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Permanent Impairment – An impairment that is more than three months in duration.

Plan of Treatment or **Plan of Care** – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services. [WAC 388-500-0005]

Prior Authorization – A process by which clients or providers must request and receive MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.
[WAC 388-500-0005]

Prior Authorization Number – An identification number issued to providers who have a signed contract(s) with MAA.
[WAC 388-500-0005]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Provider Number – An identification number issued to providers who have signed contract(s) with MAA.
[WAC 388-500-0005]

Purchase Only (PO) - A type of purchase used only when either the cost of the item makes purchasing it more cost effective than renting it, or it is a personal item, such as a ventilator mask, appropriate only for a single user.

Remittance And Status Report (RA) - A report produced by MMIS, MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. See also *Health Care Payment and Remittance Advice.* [WAC 388-500-0005]

Rental - A monthly or daily rental fee paid for equipment.

Revised Code of Washington (RCW) - Washington state laws.

Skilled Nursing Facility (SNF) - An institution or part of an institution that is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care;
- Rehabilitation services for injured, disabled or sick clients;
- Health-related care and services to individuals who, because of their mental or physical conditions, require care which can only be provided through institutional facilities

and which is not primarily for the care and treatment of mental diseases. (See Section 1919(a) of the Federal Social Security Act for specific requirements.)

Third Party - Any entity that is, or may be, liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Total Parenteral Nutrition (TPN) – See "Parenteral Nutrition."
[WAC 388-553-200]

Usual & Customary Fee – The fee that the provider typically charges the general public for the product or service.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Home Infusion Therapy/ Parenteral Nutrition Program?

[Refer to WAC 388-553-100]

The purpose of the Home Infusion Therapy/Parenteral Nutrition program is to reimburse eligible providers for the supplies and equipment necessary for parenteral infusion of therapeutic agents to medical assistance clients. An eligible client receives this service in a qualified setting to improve or sustain the client's health.

MAA's Home Infusion Therapy/Parenteral Nutrition program covers:

- Parenteral nutrition [also known as total parenteral nutrition (TPN)]; and
- Home infusion supplies and equipment.

Who is eligible to provide home infusion supplies and equipment and parenteral nutrition solutions?

[Refer to WAC 388-553-400(1)]

Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

- Have a signed Core Provider Agreement with MAA; and
- Be one of the following provider types:

    - ✓ Pharmacy provider;
    - ✓ Durable medical equipment (DME) provider; or
    - ✓ Infusion therapy provider.

What are the requirements for reimbursement?

[Refer to WAC 388-553-400(2)]

MAA pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

- Are able to provide home infusion therapy within their scope of practice;
- Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy/parenteral nutrition is an appropriate course of action;
- Have determined that the therapies prescribed and the client's needs for care can be safely met;
- Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes; and
- Meet the requirements in WAC 388-502-0020, including keeping legible, accurate and complete client charts, and providing the documentation in the client's medical file as listed on pages F.6 and F.7 of this billing instruction.

In order to bill for home infusion therapy/parenteral nutrition, MAA must first assign you an infusion therapy provider number. See the *Important Contacts* section for information on applying for an Infusion Therapy provider number.

Federally-Qualified Health Centers (FQHCs), Physicians, and Physician Clinics may provide home infusion therapy/parenteral nutrition services in a physician's office or physician clinic, unless the client resides in a nursing facility. Use the appropriate procedure codes from MAA's Physicians-Related Services Billing Instructions when billing for services.

Nursing Facilities: Some services and supplies necessary for the administration of infusion are included in the facility's per diem rate for each client. See the Home Infusion Therapy/Parenteral Nutrition Fee Schedule (Section E) to identify procedure codes that are included in the nursing facility per diem rate. A client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies are not included in the nursing facility per diem rate and are paid separately. [Refer to WAC 388-553-500(6)]

Outpatient Hospital Providers may provide infusion therapy/parenteral nutrition and bill using revenue codes. See MAA's Outpatient Hospital Billing Instructions.

Clients in a State-Owned Facility: Home infusion therapy/parenteral nutrition for MAA clients in state-owned facilities [state school, developmental disabilities (DD) facilities, mental health facilities, Western State Hospital and Eastern State Hospital] are purchased by the facility through a contract with manufacturers. MAA does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions for these clients. [Refer to WAC 388-553-500(5)]

Clients who have Elected MAA's Hospice Benefit: MAA pays for home infusion/ parenteral nutrition separate from the hospice per diem rate only when both of the following apply:

- The client has a pre-existing diagnosis that requires parenteral support; and
- That pre-existing diagnosis is unrelated to the diagnosis that qualifies the client for hospice.

When billing using a hardcopy HCFA-1500 claim form, you must enter a "K" indicator in field 19 to identify that the infusion therapy services were unrelated to the terminal diagnosis. When billing electronically, you must enter a "K" indicator in the "comments" section. [Refer to WAC 388-553-500(5)]

This is a blank page.

Client Eligibility

Who is eligible?

[Refer to WAC 388-553-300(1)]

Clients presenting DSHS Medical Identification cards with the following identifiers are eligible for home infusion therapy/parenteral nutrition:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
GA-U No Out of State Care	General Assistance – Unemployable
LCP-MNP	Limited Casualty Program – Medically Needy Program

Are clients enrolled in an MAA managed care plan eligible for home infusion therapy/parenteral nutrition?

[Refer to WAC 388-553-300(2)]

Yes! Clients who are enrolled in an MAA managed care plan are eligible for Home Infusion Therapy/Parenteral Nutrition. These clients will have an HMO identifier in the HMO column on their DSHS Medical ID cards. Home infusion therapy/parenteral nutrition must be requested through the client's Primary Care Provider (PCP) and be billed directly to the client's managed care plan. See the toll-free telephone number listed on the client's DSHS Medical ID card.

Note: Client's enrollment can change monthly. Prior to serving an MAA client enrolled in a managed care plan, you must receive approval from the plan in which the client is currently enrolled. The referral must come from a PCP participating in the plan in which the client is currently enrolled.

Newborns of clients enrolled in managed care plans are the responsibility of the plan in which the mother is enrolled for the first 60 days of life. If the mother changes plans, the baby follows the mother.

Primary Care Case Management

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider would be in a plan setting. Please refer to the client's DSHS Medical ID card for the PCCM.

Coverage

Home Infusion Therapy

All infusion therapy must be medically necessary. The medical necessity for the infusion must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for the infusion, MAA may recoup the payment.

When does MAA cover infusion therapy in the home?

[Refer to WAC 388-553-300(3)(4)]

MAA will cover infusion therapy in the home when the client meets the following criteria. The client must:

(a) Have a written physician order for all solutions and medications to be administered;
(b) Be able to manage their infusion in one of the following ways:
  (i) Independently;
  (ii) With a volunteer caregiver who can manage the infusion; or
  (iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).
(c) Be clinically stable and have a condition that does not warrant hospitalization;
(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply;
(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent; and
(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:
  (i) Running water;
  (ii) Electricity;
  (iii) Telephone access; and
  (iv) Receptacles for proper storage and disposal of drugs and drug products.

MAA evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. See page D.2. [WAC 388-553-500]

Parenteral Nutrition

All parenteral nutrition must be medically necessary. The medical necessity for the product being supplied must be evident in the diagnosis code on the claim. If the diagnosis code does not indicate the medical need for parenteral nutrition, MAA may recoup the payment.

When is Parenteral Nutrition covered?

[Refer to WAC 388-553-300(5)]

To receive parenteral nutrition, a client must meet the conditions under Home Infusion Therapy (see page C.1) as follows:

(a) Have hyperemesis gravidarum or an impairment involving the gastrointestinal tract that lasts 3 months or longer, where either of these conditions prevents oral or enteral intake to meet the client's nutritional needs;
(b) Be unresponsive to medical interventions other than parenteral nutrition; and
(c) Be unable to maintain weight or strength.

When is Parenteral Nutrition NOT covered?

[Refer to WAC 388-553-300(6)]

MAA does not cover parenteral nutrition program services for a client who has a functioning gastrointestinal tract when the need for parenteral nutrition is only due to:

(a) A swallowing disorder;
(b) A gastrointestinal defect that is not permanent unless the client meets the criteria below;
(c) A psychological disorder (such as depression) that impairs food intake;
(d) A cognitive disorder (such as dementia) that impairs food intake;
(e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;
(f) A side effect of medication; or
(g) Renal failure or dialysis, or both.

When does MAA cover parenteral nutrition for a client who has a condition expected to last less than three months?

[Refer to WAC 388-553-300(7)]

MAA covers parenteral nutrition for a client whose gastrointestinal impairment is expected to last less than three months when:

(a) The criteria on page C.1 are met;
(b) The client has a written physician order that documents the client is unable to receive oral or tube feedings; and
(c) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

When does MAA cover Intradialytic Parenteral Nutrition (IDPN) solutions?

[Refer to WAC 388-553-300(8)]

MAA covers intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and
(b) The client meets the criteria on page C.1 (client eligibility) and items a.-c. on page C.2 under "**When is Parenteral Nutrition Covered?"**

What documentation is required to be in the client's medical record and available to MAA upon request when providing parenteral nutrition to Medical Assistance clients?

See page F.6 – Specific to Home Infusion Therapy/Parenteral Nutrition Program.

MAA evaluates a request for home infusion therapy supplies and equipment or parenteral nutrition solutions that are not covered or are in excess of the home infusion therapy/parenteral nutrition program's limitations or restrictions, according to WAC 388-501-0165. See page D.2. [WAC 388-553-500]

This is a blank page.

Authorization

Written/fax authorization does not override the client's eligibility or program limitations. Not all categories of eligibility receive all services. For example: Infusion pumps are not covered under the Family Planning Only program.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is a paper authorization process available to providers. It is used for Limitation Extension requests (see below) and for services noted in Washington Administrative Code (WAC) and billing instructions as needing prior authorization.

For the Home Infusion Therapy/Parenteral Nutrition Program, you must obtain written/fax authorization for:

- Miscellaneous parenteral therapy supplies (**procedure code B9999**). See page E.8 for further details and for the "Justification for use of Miscellaneous Parenteral Supply Procedure Code (B9999) Form" that must accompany your written/fax authorization request; and

- Limitation Extensions (see next page).

How do I obtain written/fax authorization?

Authorization may be obtained by sending a request, along with any required forms, to:

Medical Assistance Administration
Division of Medical Management
Home Infusion Therapy/Parenteral Nutrition Program
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Expedited prior authorization (EPA)

What is the EPA process?

MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

When do I need to bill with a 9-digit EPA number?

Expedited prior authorization is required for those procedure codes listed in the Fee Schedule which state "Must bill using EPA code." The 9-digit EPA number listed in the "Description" column next to these procedure codes must also be on the claim.

🗁**BILLING**:	Enter the EPA number (**870000XXX**) in field 19 (Reserved for Local Use) on the HCFA-1500 claim form. If you have two or more EPA numbers for the same claim, list them both in field 19. DO NOT HANDWRITE THE EPA NUMBER ONTO THE CLAIM. (See "Guidelines for completing the HCFA-1500 claim form.")

Limitation Extension

What is a Limitation Extension?

Limitation extension (LE) is authorization for cases when MAA determines that it is medically necessary to provide more units of service than allowed in MAA's WAC and billing instructions.

How do I get LE authorization?

LE authorization may be obtained by using the written/fax authorization process. See address and fax number on previous page.

Your request must include the following:

1. Name of agency and provider number;
2. Client's name and PIC number;
3. Procedure code and description of supply needed;
4. Copy of the original prescription; and
5. Explanation of client-specific medical necessity to exceed limitation.

The Home Infusion Therapy/Parenteral Nutrition Program Fee Schedule (previously found on pages E.1 – E.2) is now located in the appendix. To view or download the Fee Schedule, click Appendix.

This page intentionally left blank.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

> ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The time-periods do not apply to overpayments that the provider must refund to DSHS. After the time-periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

> ☞ **Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid (otherwise known as "dual-eligible"), **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page K.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Note:**

✓ Medicare/Medicaid billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MAA uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

The Medical Assistance Administration (MAA) is required by federal regulation to determine the liability of third-party resources that are available to MAA clients. All resources available to the client that are applicable to the costs of medical care must be used. Once the applicable resources are applied, MAA may make payment on the balance if the third-party payment is less than the allowed amount.

To be eligible for MAA programs, a client must assign his/her insurance rights to the state in conformance with federal requirements.

It is the provider's responsibility to bill MAA appropriately after pursuing any potentially liable third-party resource when:

- Health insurance is indicated on the client's DSHS Medical ID card; or
- There is a possible casualty claim; or
- You believe insurance is available.

> If you would like assistance in identifying an insurance carrier, call the Third-Party Resource Program at 1-800-562-6136, or refer to the TPL Carrier Code List on MAA's web site at http://maa.dshs.wa.gov.

Exception:

Due to federal requirements, the following services will not be denied for third-party coverage unless the TPL code is **HM, HI, or HO:**

- ✓ Outpatient preventative pediatric care;
- ✓ Outpatient maternity-related services; and
- ✓ Accident related claims, if the third party benefits are not available to pay the claims at the time they are filed, per 42 CFR 433.139(c).

Indicate all available insurance information on the claim form. MAA pays the claim and pursues the third-party insurance.

You must pursue collection from the subscriber when the client is not the subscriber and the insurance company makes a benefit payment to the subscriber. Under these circumstances, the client is under no obligation to pay unless he/she is the insurance subscriber.

Although the billing time limit for MAA is 365 days, an insurance carrier's time limit on billing allowances may be different. It is your responsibility to meet the insurance carrier's requirement relating to billing time limits prior to any payment by MAA.

☞ **Note:** If you receive payment from MAA in excess of the amount due, you may refund the excess to the Office of Financial Recovery, or you may submit an adjustment request to MAA to withhold money from future checks. A copy of the appropriate MAA Remittance and Status Report showing the original payment and copy of the insurance EOB, if available, should be attached to either the check or the adjustment request, whenever possible.

Mail refund checks to:

OFFICE OF FINANCIAL RECOVERY - MED
PO BOX 45862
OLYMPIA WA 98504-5862

What records must be kept in the client's file?

Specific to Home Infusion Therapy/Parenteral Nutrition Program
[WAC 388-553-400]

- For a client receiving infusion therapy, the file must contain:
  - ✓ A copy of the written prescription for the therapy;
  - ✓ The client's age, height, and weight;
  - ✓ The medical necessity for the specific home infusion service;
- For a client receiving parenteral nutrition, the file must contain:
  - ✓ All the information listed above;
  - ✓ Oral or enteral feeding trials and outcomes, if applicable;
  - ✓ Duration of gastrointestinal impairment; and
  - ✓ The monitoring and reviewing of the client's lab values:
    - ➢ At the initiation of therapy;
    - ➢ At least once per month; and
    - ➢ When the client and/or the client's lab results are unstable.

General for all providers [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Pertinent medical history;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

This is a blank page.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions for Completion

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the DSHS Medical ID card consisting of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, First Steps, and Medicare, etc., are ~~inappropriate~~ entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.* Please specify twin A or B, triplet A, B, or C here. If you have more than one EPA number to bill, place both numbers here.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. Prior Authorization Number: When applicable. If the service or equipment you are billing requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.

24. Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.

24A. Date(s) of Service: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 8, 2003 = 100803).

24B. Place of Service: Required. Enter the following code:

Code	To Be Used For
12	Client's residence
32	Nursing facility (formerly ICF)
31	Nursing facility (formerly SNF)
33	Custodial care facility
65	End Stage Renal Disease Treatment Facility

24D. Procedures, Services or Supplies CPT/HCPCS: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. Diagnosis Code: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. $ Charges: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. Days or Units: Required. Enter the total number of days or units (up to 99,999) for each line. These figures must be whole units.

25. Federal Tax ID Number: Leave this field blank.

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field. Do not put a Medicare payment in this field.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**
B) An identification number for individuals only when they are part of a group practice (see below).

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MC010667JOHNSB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JOHNSON MARY C

3. PATIENT'S BIRTH DATE MM 01 DD 06 YY 67 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 MAPLE LANE

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR SMITH

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE: LN 3 EPA/870000869

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 850 . 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11	11	03	11	11	03	12		B4164		850	2500	1				
2	11	01	03	11	30	03	12		E0779	RR	850	2000	1				
3	11	11	03	11	11	03	12		E1399		850	500	1				
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 5000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 5000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

DORIS JONES
100 MAIN STREET
ANYTOWN WA 98000

PIN# 7890123 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Infusion Therapy Equipment/Parenteral Nutrition Program

Effective July 1, 2006

Code	EPA/MOD	Nursing Home Per Diem	Max Allow Fee
A4220		Y	$25.50
A4221		Y	$22.26
A4222		Y	$44.17
A4230		N	$208.76
A4231		N	$139.16
A4232		N	$82.01
A4244		Y	$1.06
A4245		Y	$2.33
A4246		Y	$2.97
A4247		Y	$4.72
A4927		Y	$6.55
A4930		Y	$0.60
B4164		N	$16.48
B4168		N	$24.01
B4172		N	$32.89
B4176		N	$46.46
B4178		N	$55.78
B4180		N	$23.63
B4185		N	$10.89
B4189		N	$172.31
B4193		N	$222.67
B4197		N	$271.08
B4199		N	$309.77
B4216		N	$7.49
B4220		N	$7.76
B4222		N	$9.57
B4224		N	$24.25
B5000		N	$11.52
B5100		N	$4.51
B5200		N	$3.90
B9004	NU	N	$2,446.04
B9004	RR	N	$357.84
B9006	NU	N	$2,446.04
B9006	RR	N	$357.84
B9999	Requires prior authorization.	N/A	B.R.
E0776	NU	Y	$101.98

E0776	RR	Y	$10.20
E0779	NU	N	$167.30
E0779	RR	N	$16.73
E0780	NU	N	$10.37
E0781	NU	N	$2,648.70
E0781	RR	N	$264.87
E0784	NU	N	$4,174.90
E0784	RR	N	$417.49
E0791	NU	N	$3,162.00
E0791	RR	N	$316.20
E1340		N	$17.43
E1399	870000855	Y	$3.89
E1399	870000857	N	B.R.
E1399	870000858	Y	$7.25
E1399	870000869	Y	$5.39
K0601		N	$1.10
K0602		N	$6.36
K0603		N	$0.57
K0604		N	$6.09
K0605		N	$14.60

EPA = Expeditied Prior Authorization
NU =New
RR = Rental
B.R. = By Report